Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Home and Community Based Services - Intellectual Disabilities (ID) Waiver

C. Waiver Number:IA.0242
Original Base Waiver Number: IA.0242.

D. Amendment Number:IA.0242.R05.03

E. Proposed Effective Date: *(mm/dd/yy)*

12/01/17

Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to change the service rate reimbursement methodology for daily Supported Community Living (SCL), Residential Based Supported Community Living (RBSCL), full day Day Habilitation, and full Day Adult Day Care (ADC) services. Current provider rate reimbursement for SCL and RBSCL is based on a retrospectively limited prospective rate setting methodology. Day Habilitation and Adult Day Care are reimbursed on a fee schedule. With this amendment, the aforementioned services will be reimbursed on a tiered rate fee schedule methodology that is based on acuity level of a member as determined through a core standardized assessment (CSA) tool. The current approved CSA for the Intellectual Disability (ID) Waiver is the Supports Intensity Scale ® (SIS). Based on results of the SIS assessment, members are placed on one of six tiers. A rate is associated with each assessed tier.
For the purpose of service reimbursement, the use of tiered rates will be cost neutral to the costs of service provision under the previous funding methodology. Providers will receive a tiered rate based on the acuity level of the members they serve based on a core standardized assessment. Because tier rates are based on member need and not provider based costs, individual service providers may receive more or less funding than previously received for providing the same services. To address the change in provider revenues, the IME will transition individual provider tiered rates over an 19 month time period. Providers with higher than average revenue shortfalls and providers with higher than average revenue gains will receive a progressive blended tier rate to assist providers to adjust business practices under the new funding process. Blended rates will begin December 1, 2017, and adjusted again on July 1, 2018. Final tiered rates will be fully implemented statewide on July 1, 2019. There are approximately 70 percent of the affected providers will receive blended transitional rates. Providers with minimal revenue shortfalls or gains (approximately 30 percent) will not receive transitional tiered rate funding, but rather will use the standard tier rates effective December 1, 2017.
The permanent standard tiered rates will be posted to the DHS website. Individual blended tiered rates will be provided to the affected providers by the IME
Specific changes made with this amendment include:
• Remove the Extended Day adult day care service option. ADC service options will continue to include 15 – minute units, ½ day and full day units.

• A change to transportation services provided as part of the Residential Based Supported Community Living (RBSCL). Providers will be responsible for all transportation costs required of the member, with exception of NEMT and transportation to and from school. Transportation, the HCB service, will not be available to members accessing RBSCL services.

• A change to transportation services provided as part of the daily Supported Community Living (SCL) service. Providers will be responsible for all transportation costs required of the member, with exception of NEMT. Transportation, the HCB service, will not be available to members accessing daily SCL services.

• The daily SCL unit reimbursement cap is eliminated and will reflect the tiered rate associated with the new fee schedule reimbursement process on a tiered rate methodology.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	C-1a.
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☑ Appendix I – Financial Accountability	I-2a.
☐ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Change provider reimbursement payment methodology

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Home and Community Based Services - Intellectual Disabilities (ID) Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IA.0242
Waiver Number:IA.0242.R05.03
Draft ID: IA.011.05.04

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/14
Approved Effective Date of Waiver being Amended: 07/01/14

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
Iowa High Quality Healthcare Initiative-Submitted
Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☑ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Waiver Program Summary

The goal of the Iowa HCBS Intellectual Disability (ID) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet intermediate care facility for individuals with intellectual disabilities (ICF/IID) (as defined in 42 CFR §440.150) level of care. IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care revaluations for fee-for-service participants. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

If the applicant is deemed eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the individual will have the option to choose between various traditional and self-directed services.

Services include adult day care, consumer directed attendant care, day habilitation, home and vehicle modification, home health aide, interim medial monitoring and treatment, nursing, personal emergency response, prevocational, respite, supported community living, supported community living-residential based, supported employment, transportation, financial management services and independent support brokerage services, self directed personal care, individual directed goods and services, and self directed community and employment supports.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside

in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s)

of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Wines

First Name: Brian

Title: Program manager

Agency: Iowa Department of Human Services/Iowa Medicaid Enterprise

Address: 100 Army Post Road

Address 2:

City: Des Moines

State: **Iowa**

Zip: 50315

Phone:

(515) 256-4661 **Ext:** ☐ **TTY**

Fax:

(515) 725-1360

E-mail:

bwinesdhs.state.ia.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Iowa**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Mikki Stier

State Medicaid Director or Designee

Submission Date: Dec 5, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Stier

First Name: Mikki

Title: Medicaid Director

Agency: Iowa Medicaid Enterprise

Address: 100 Army Post Road

Address 2:

City: Des Moines

State: **Iowa**

Zip: 50315

Phone: (515) 256-4621 **Ext:** ☐ **TTY**

Fax: (515) 725-1360

E-mail: mstier@dhs.state.ia.us

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Transition plan – Intellectual Disability (ID) Waiver Tiered Rate Amendment

Iowa is proposing to amend the Intellectual Disability Waiver to change the rate reimbursement methodology for daily Supported Community Living (SCL), Residential Based Supported Community Living (RBSCL), full day Day Habilitation, and full Day Adult Day Care (ADC) services. Current provider rate reimbursement for SCL and RBSCL is based on a retrospectively limited prospective rate setting methodology. Day Habilitation and Adult Day Care are reimbursed on a fee schedule. Effective December 1, 2017, these services will use a fee schedule base on a tiered rate reimbursement methodology.

Due to the potential impact of funding of services to provider affected by the change to the tiered rate methodology, two areas of the amendment may require time for providers to transition to the new funding process.

Potential Impact to providers that may require time to implement:

• Remove the Extended Day adult day care service option.
• The daily SCL unit tiered rate reimbursement will decrease revenues for about 30 percent of providers.

To address these provider issues, the state has developed the following activities to assist providers with the transition to tiered rates:

1. Remove extended day adult day care service.

Summary: When developing the tiered rates for the adult day care services, it was identified that a minimal number of members on the ID waiver were accessing extended day adult day services. Because of the minimal numbers, the department decided to combine the full day and extended day service into one service with one tiered rate. The rate development process conducted by the department's contracted actuarial firm used historical costs associated with both the full day and extended day services to arrive at the full day tiered rate. As such, adult day care service providers should see minimal changes if any in service reimbursement.

Review of the fee for services (FFS) members on the ID waiver identified that no one is currently accessing extended day ADS. Since this change does not impact any current members and all future members will be able to get their adult day care services needed met either through the full day adult day care service, there is no need to transition providers to the new rate

2. Providers with reduced revenues due to tier rate implementation

Summary: For the purpose of service reimbursement, the use of tiered rates will be cost neutral to the costs of service provision under the previous funding methodology. Providers will receive a tiered rate based on the acuity level of the members they serve derived from a core standardized assessment. Because tier rates are based on member need and not provider based costs, individual service providers may receive more or less funding than previously received for providing the same services prior to tiered rate implementation. To address the change in provider revenues, the IME will phase in individual provider tiered rates for Supported Community Living (SCL) services over a 19 month time period. In order to maintain cost neutrality, revenues from providers with higher than average revenue gains will be used to offset the providers with higher than average revenue shortfalls. The revenue offsets will be used to allow providers with revenue shortfalls time to adjust their business practices to operate within the new funding methodology. Providers with higher than average revenue shortfalls (about 35% of the providers) and providers with higher than average revenue gains (about 35% of the providers) will receive a progressive blended tier rate over a19 month time period. Blended rates will begin December 1, 2017, and adjusted again on July 1, 2018. Providers with minimal revenue shortfalls or gains (about 30 %) will not receive phased in transitional tiered rate funding, but rather will use the standard tier rates effective December 1, 2017. The individual provider blended tiered rates will be sent to the affected providers by the IME. Final tiered rates will be fully implemented statewide for all providers on July 1, 2019.

The final standard tiered rates are posted to the DHS website:

http://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Iowa assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Section 1: Assessment

Iowa proposes a multifaceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general categories (not specific providers or locations) that are likely to be in compliance; not in compliance; presumed to be non-HCBS; or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS settings during provider enrollment and re-enrollment; evaluating settings through the existing HCBS quality assurance onsite review process and the provider self-assessment process; and monitoring of Iowa Participant Experience Survey (IPES) results for participants experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver participants.

4/1/2014 - 7/31/2014: Settings Analysis - State identified HCBS settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into categories (Yes - settings fully compliant, Not Yet - settings that will comply with changes, Not Yet - setting is presumed non-HCBS but evidence may be presented for heighted scrutiny review, and No - setting do not comply) The Iowa HCBS Settings Analysis is being submitted as one component of the transition plan.

5/1/2014 - 12/31/2014: Provider Enrollment Processes - State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening by the Iowa Medicaid Enterprise (IME), provider credentialing by the managed care behavioral health organization (BHO), and HCBS provider certification by the HCBS Quality Assurance and Technical Assistance Unit.

5/1/2015 - 12/31/2015: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Participant Addresses - State will use GIS to analyze locations of provider sites and participant addresses to identify potential areas with high concentration of HCBS.

12/1/2014 - ongoing: Onsite assessment - The State will incorporate review of settings into the review tools used by the HCBS Quality Assurance and Technical Assistance Unit for on-site reviews. Settings will be assessed during recertification reviews, periodic reviews, focused reviews, and targeted reviews. State will identify providers with sites of service that have the characteristics of HCBS or the qualities of an institution.

10/1/2014 - ongoing: Enrolled HCBS providers self-assessment - The state will modify the Provider Quality Management Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. The annual self-assessment will be released to providers annually on October 1 and due to IME annually on December 1, with results compiled by February 28. The State will

release the “Iowa Exploratory Questions for Assessment of HCBS Settings” document to assist providers in identifying the expected characteristics of HCBS.

8/1/2014 - ongoing: Other projects collecting HCBS setting data - State provider association will provide information and input from residential providers to the state.

12/1/2014 - ongoing: Iowa Participant Experience Survey (IPES) - State will continue to monitor IPES results to flag participant experience that is not consistent with assuring control over choices and community access.

5/1/2015 - By 3/17/2019: Onsite Assessment Results Report - State compiles and analyzes findings of onsite assessments annually by July 31, with the final report completed by 3/17/19. Findings will be presented to Iowa DHS leadership and stakeholders.

Section 2: Remediation Strategies

Iowa proposes a remediation process that will capitalize on existing HCBS quality assurance processes including provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Iowa will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings timely may be subject to sanctions ranging from probation to disenrollment.

6/1/2014 - 7/31/2016: Informational Letters - State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO and MCO will provide the same information to provider network.

12/1/2014 - 7/31/2015: Iowa Administrative Code - State will revise administrative rules chapters 441-77, 78, 79, and 83, to reflect federal regulations on HCBS settings. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of participant control of their environment and access to community. MCOs will develop the same standards for provider network.

8/1/2015 - 12/31/2015: Provider Manual Revisions - State will revise HCBS provider manual Chapter 16K to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. MCOs will incorporate the same information into relevant provider network manuals.

12/1/2014 - ongoing: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment - IME Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that HCBS settings are evaluated when appropriate. When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements.

12/1/2014 - ongoing: Provider Assessment Findings - State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.

12/1/2014 - 3/16/2019: Provider Individual Remediation - HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis. Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review.

12/1/2014 - 3/16/2019: Data Collection - State, BHO, and MCOs will collect data from reviews, technical assistance, updates, etc. to track status of remediation efforts. Data will be reported on a regular basis or ad hoc to DHS management and CMS.

12/1/2014 - 3/1/2019: Onsite Compliance Reviews - State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.

12/1/2014 - 3/16/2019: Provider Sanctions and Disenrollments - State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.

12/1/2014 - 3/16/2019: Participant Transitions to Compliant Settings - If relocation of participants is necessary, the state will work with case managers, service workers, and care coordinators to ensure that participants are transitioned to settings meeting HCBS Setting requirements. Participants will be given timely notice and due process, and will have a choice of alternative settings through a person centered planning process. Transition of participants will be comprehensively tracked to ensure successful placement and continuity of service.

Section 3: Public Comment

Iowa proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments, and through taking public comments directly by mail. Iowa has also previously held comment periods in May 2014 and November 2014 which included solicitation of comments through stakeholder forums. In addition to posting the transition plan and related materials on the Iowa Medicaid website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, NAMI Iowa, ASK Resource Center, Area Agencies on Aging, County Case Management Services, and MHDS Regional Administrators.

3/9/2015 - 3/13/2015: Announcement of Public Comment Period - State released a White Paper, the Draft Transition Plan, and Draft Settings Analysis on the state website. Informational Letters were released and sent to all HCBS waiver providers, case managers and DHS service workers. Stakeholders (listed above) were contacted directly to inform them of the public comment period. A dedicated email address (HCBSsettings@dhs.state.ia.us) was established to receive public comments. Tribal notices were sent. Notices were filed in newspapers. Printed versions were made available in DHS local offices statewide, along with instructions on submitting comments via mail.

3/16/2015 - 4/15/2015: Public Comment Period for Proposed Transition Plan - State will share transition plan with the public in electronic and non-electronic formats, collect comments, develop state responses to public comments, and incorporate appropriate suggestions into transition plan. The Response to Public Comments document will be posted to the DHS website and a summary provided to CMS. Previous comment periods were held in May 2014 and November 2014, which included stakeholder forums.

4/15/2015 - 3/16/2019: Public Comment Retention - State will safely store public comments and state responses for CMS and public consumption.

4/15/2015 - 3/16/2019: Posting of Transition Plan Iterations - State will post each approved iteration of the transition plan to its website.

7/1/2015 - By 3/17/2019: Assessment Findings Report - State shares the findings of the onsite assessment annually by July 31.

Iowa HCBS Settings Analysis - This Settings Analysis is general in nature and does not imply that any specific provider or location is noncompliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan, including but not limited to onsite reviews, provider annual self-assessments, IPES data, provider surveys, and GIS analysis.

Category: YES – Settings presumed fully compliant with HCBS characteristics
--Participant owns the housing, or leases housing that is not provider owned or controlled.
--Supported employment provided in an integrated community setting

Category: NOT YET – Settings may be compliant, or with changes will comply with HCBS characteristics
--Residential Care Facilities (RCFs) of any size
--Apartment complexes where the majority of residents receive HCBS
--Disability-specific camp settings (except Respite)
--Five-bed homes previously licensed as RCFs

--Provider owned or controlled housing of any size
--Multiple locations on the same street operated by the same provider (including duplexes and multiplexes)
--Disability-specific farm communities
--Assisted Living Facilities
--Services provided in a staff participant's home (except Respite)
--Day program settings located in a building that also provides other disability-specific services, or where provider offices are located.

Category: NOT YET - Setting is presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review
--Located in a building that also provides inpatient institutional treatment
--Any setting on the grounds of or adjacent to a public institution
--Settings that isolate participants from the broader community
Category: NO – Settings do not comply with HCBS characteristics
--Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite)
--Nursing Facilities/Skilled Nursing Facilities
--Hospitals
--Institutions for Mental Disease (IMD)

Public comment was taken from March 16, 2015 through April 15, 2015. The transition plan was posted on the IME website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The transition plan has been available at that location since March 12, 2015. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on March 9, 2015. The transition plan was available for non-electronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally recognized tribes on March 9, 2015.

Summary of Comments:

Comments that resulted in changes to the transition plan:
There were no comments received that resulted in changes to the transition plan.

Comments for which the State declined to make changes to the transition plan or settings analysis document:
There were numerous comments submitted which did not ask for changes to the transition plan, but rather were seeking clarification or interpretation of the federal regulation or posed operational questions about how the state would carry out activities in the transition plan.

Four commenters suggested that various aspects of the transition plan need to be updated to reflect the role that the Managed Care Organizations (MCOs) will have related to the Iowa High Quality Health Care Initiative. The state declined to makes changes based on the comment and explained in the response that Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future, and that there will be another public comment period related to those amendments at that time.

Two commenters expressed concern about engaging consumers, families and advocates in the transition plan. The state declined to make changes based on the comment and explained the various ways that input from consumers and advocates has been sought in the development of the plan and expressed that consumer and advocate involvement will continue throughout implementation.

One commenter suggested that the state conduct a more exhaustive review of its provider network to identify examples of gated communities and farmsteads, a category of service-provision they believe to be impermissible. The state declined to make any changes to the transition plan, and in our response explained that the assessment process outlined in our plan will ensure that all residential sites will be reviewed. Our response additionally explained that we have released a guidance document on settings with the potential effect of isolating individuals which does include settings similar to farmsteads and gated communities, and which identifies that these settings may indicate increased risk of isolating people from the broader community.

One commenter asked that the role of the state's Mental Health and Disability Services (MHDS) Regions be included in the plan. The state declined to make this change, explaining that the MHDS Regions are already listed as stakeholders in the

plan.

One commenter asked that the plan be changed to eliminate the distinction between provider owned and controlled housing, as the commenter believed this had been eliminated from the regulation. The state declined to make this change and explained in the response that the federal regulation does still set out additional requirements for provider owned and controlled settings.

One commenter suggested that the "players" column, which existed in an early draft of the transition plan, but was later removed, should be added back into the plan. The state declined to make this change and explained in the response that the responsibility for completion of the activities listed in the transition plan lies with the IME, and other stakeholders are already noted in the description column for each item or in the explanatory narrative at the top of each section.

One commenter expressed that activities within the transition plan should not have end dates listed as "ongoing". The state declined to make this change and explained in the response that our approach utilizes an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline, and our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis.

One commenter suggested that the actions or omissions that would trigger the requirement of a corrective action plan (CAP) should be listed in the transition plan. The state declined to make this change, explaining that any finding of noncompliance will trigger a CAP.

One commenter suggested that in regard to provider remediation, rather than the State allowing "reasonable time frames" for large infrastructure changes, the State should impose specific timeframes and deadlines. The state declined to make a change because we believe the commenter misunderstood the intent of the item. Our response to the comment explained that the timeframes that will be set out in any given CAP will be specific deadlines for that provider and location. The "reasonable timeframes" language needs to be read in the context of the previous sentence in the plan, which indicates that in reviewing a CAP, the state will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Public Comment Summary

I. Comments received

The proposed ID Waiver amendment to change the rate payment methodology for daily Supported Community Living (SCL), full day Day Habilitation and full day Adult Day Care services to a tiered rate methodology was posted to the DHS webpage and available in all DHS county offices from October 11, 2017 through November 11, 2017.

The department received 43 comments on the proposed service funding change to a tiered rate methodology for SCL, Day Habilitation, and Adult Day Services. Responses were received from family members, providers and advocates. All public comments were received on or after November 3, 2017. This date correlates with the date that letters were sent by the Iowa Medicaid Enterprise (IME) notifying providers of the individual provider specific tiered rates that will go into effect on December 1, 2017. All comments received expressed concerns on the fiscal impact to providers or the services received by their family member. No comments were received in support of the tiered rate methodology. Five providers provided comments. Thirty of the responders were identified as representing either family members of service recipients or employees of two HCBS ID Waiver providers of supported community living and day habilitation. The majority of comments received came from areas of the state where two of the providers who commented currently operate.

Summary:
1. Twenty-one comments received included the following language or a minor variation of this comment:

I'd like to express my grave concern about the timeline for implementation of tiered rates for ID Waiver population. Fewer than thirty days is not enough time for members, families and providers to adjust service plans and business models to deal

with these changes, especially in light of the end of the AmeriHealth Caritas contract, which will place additional administrative burden on agencies at the same time as the tiered rate implementation.

I would request, along with others, a public hearing on this matter

2. Eleven comments address the negative impact the tiered rates would have on services received because of lower service reimbursement rates.

3. Twelve comments expressed concerns with the use of the Supports Intensity Scale ® (SIS) to either determine a funding tier for the member or that families and providers had limited understanding of the SIS or access to the SIS scores.

4. Twenty-five comments addressed the short notification time period to providers for the rate changes. Comments stated that a 30 day notice of rate changes was not enough time for providers to adjust their business practices. It was requested to delay the implementation of tiered rates and not go into effect on December 1, 2017.

5. Nine comments addressed opposition of the inclusion of transportation in the SCL rate. Comments include:
• Why the inclusion of transportation in the SCL service was not discussed with the provider stakeholder group.
• Providers do not have enough time to set up and pay for transportation starting 12/1/17.
• Transportation costs that were put into SCL rates are not enough to cover all transportation costs of individual members
• Members will lose critical transportation to keep them connected to community resources.

6. Twenty-four comments specifically asked that public hearings be held throughout the state to allow for comments from members, guardians, providers, and advocates be heard.

7. Twenty-two comments stated that the exit of AmeriHealth Caritas as one of the MCOs within the state on 12/1/17 complicates the move to implementing tiered rates and could cause disruption in services provided and payment to providers.

Other comments that were received from three or fewer commenters:
1. It does not make sense to group individuals into categories for the purpose of funding – they are individuals.
2. Did the department use any geographic or regional wage/ employment data etc. in the process as outlined in the CMS guidance for rate setting process?
3. The IME did not sufficiently address or partner with providers of services to people with significant behavioral challenges.
4. I have been told that MFP (Money Follows the Person) rates were not included in the tier process.
5. The legislators may have made a hasty decision to implement tiered rates.

ANALYSIS AND ACTIONS TAKEN

The 2017 Iowa Legislature directed the department to use tiered rates as a payment methodology in Iowa House File 653 (HF 653), section 93. The department has been working to develop a tiered rate methodology with provider stakeholder and Managed Care Organization involvement since December 2016. Providers have had opportunity for input into the development and implementation of tiered rates through the stakeholder group and the public notice of the ID Waiver proposed amendment. Many of the stakeholder group recommendation were incorporated into the final tier rate development. Opportunity for additional feedback will be available during the public comment time period for the tiered rate rules

The department has projected that Daily SCL tiered fee schedule rates will affect provider revenues in three ways: reductions, increases or relative neutrality. As a result, a transitional phase-in plan has been established as described below:
• Some providers will experience overall revenue reductions. Daily SCL tiered rate reimbursement for these providers will be higher than the final established tiered rates during the phase-in time period.
• Some providers will experience revenue increases. Daily SCL tiered rate reimbursement for these providers will be lower than the final established tiered rates during the phase-in time period.
• Some providers will have moderate revenue loses or gains. Daily SCL tiered rate reimbursement will begin at the tiered rates fee schedule on December 1, 2017.

Implementation of tiered rates for Day Habilitation and Adult Day Care services will use the tiered rate fee schedule beginning December 1, 2017. Tiered rate reimbursement for Daily SCL will be phased in over 19 months beginning December 1, 2017, with the use of the tiered rate fee schedule effective July 1, 2019. Providers who experience overall

revenue reductions or increases will have the individual provider phase-in rates during the 19 month phase-in time period to give providers time to adjust their business practices to the new reimbursement rates. Individual provider phase in tiered rates have been sent to the identified providers by the IME.

Any delays in implementation of the transition to tiered rates for the fee for service population will cause additional issues for providers as the MCO's have chosen to utilize tiered rates as of December 1, 2017 and changes to MCO and state computer systems have been made to recognize this start date for the new payment methodology. The amount paid to a provider for a MCO member's services is a contractual relationship between the provider and MCO.

The Supports Intensity Scale ® (SIS) assessment is a nationally recognized valid and reliable assessment tool developed and owned by the American Association on Intellectual and Developmental Disabilities (AAIDD). In addition to its use by a case manager in the development of the member's service plan, the SIS may be used to assign resource allocation based on the acuity level of a member. The SIS is conducted by an independent entity from the department and MCOs and has been used with the ID Waiver population for over three years. The SIS assessors conduct the assessment but do not determine the tier assignment. The tiered rate tier assignment does not change the member's needs or service plan activities but does determine the reimbursement amount available to the provider to bill for services provided to the member. The tiered rates were developed based historical costs of providing services attributed to members within each tier.

AmeriHealth Caritas, the largest of the three MCOs operating in the state of Iowa, has chosen to exit operations in Iowa effective December 1, 2017. Transition plans are being developed for the exit to assure continuity of care. The state believes that the transition to tiered rates on December 1st will benefit the LTSS system as the tiered rates will be standardized for the member and the provider. The tiered rates will be used as the floor rates for provider reimbursement and individual contracts with providers will require less negotiation.

Transportation, the service, will be incorporated into the reimbursement rates for daily SCL service. All transportation costs attributed to daily SCL members was added into the tiered rates. Non-emergency medical transportation (NEMT) will continue to be paid separately and is not a requirement for payment through the daily SCL rate.

The department received no comments regarding the tiered rate phase in time period designed to mitigate effects of implementing tiered rates.

The department received no formal comments to the proposed amendment from entities, either members or providers, which will benefit from the new tiered rate funding methodology.

Based on the above, no changes or modification will be made to the ID Waiver amendment based on public comments received.

II. Tribal Consultation

No questions or comments were received regarding the proposed amendments.